

MAIN STUDY - ROUND 25
COMMUNITY COMPONENT
HH. HOME HEALTH UTILIZATION AND EVENTS

- HH1. (Other than what we just talked about,) [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you been/has SP been/was SP) helped **at home** by any (other) health or medical professionals, such as those listed on this card? [Health professionals include nurse (visiting nurse, private duty nurse, etc.), doctor, social worker, therapist, and hospice worker.]

SHOW CARD HH1

HHPRPROF	YES	1 (HH2)
	NO	2 (HH18)
	REFUSED	-7 (HH18)
	DON'T KNOW	-8 (HH18)

- HH2. What is the name of the health professional who helped (you/SP) at home [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]? [ENTER NAME OF PERSON WHO HELPED, NOT NAME OF PLACE OR ORGANIZATION.] [ENTER ONLY ONE PROVIDER.]

PROVNAME

- HH3. What kind of health professional is (PROVIDER)?

PROVSPEC

PROVSPOS

- HH4. Who does (HH2 PROVIDER) work for, that is, for what place or organization? [PROBE: Or does (HH2 PROVIDER) work for himself/herself?]

WORKSFOR	NAME OF ORGANIZATION GIVEN	1 (HH5)
	WORKS FOR SELF	2 BOX HH1
	REFUSED	-7 BOX HH1
	DON'T KNOW	-8 BOX HH1

- HH5. [Who does (HH2 PROVIDER) work for, that is, what place or organization?] [PROBE: Who would (you/SP) call if (HH2 PROVIDER) did not show up?] [ENTER OR SELECT ONLY ONE PROVIDER.]

PROVNAME

SUBPROV

HH6. What kind of place or organization is (HH5 PROVIDER)?

HHPLACE	MANAGED CARE PLAN (SUCH AS HMO)	1	BOX HH1
	MEAL PROGRAM (SUCH AS MEALS ON WHEELS)	2	(HH7)
	VISITING NURSE ASSOCIATION	3	BOX HH1
	HOME HEALTH AGENCY	4	BOX HH1
	HOSPITAL	5	BOX HH1
	PRIVATE PHYSICIAN/GROUP PRACTICE	6	BOX HH1
	HOSPICE	7	BOX HH1
	REHABILITATION OR SPORTS MEDICINE THERAPY	8	BOX HH1
	LOCAL GOVERNMENT ORGANIZATION	9	(HH11)
	CHURCH OR COMMUNITY ORGANIZATION	10	(HH11)
	ASSISTED LIVING/RETIREMENT HOME	11	BOX HH1
	OTHER (SPECIFY) _____		
HHPLACOS	_____	91	BOX HH1

HH7. Between (PREV. ROUND INT. DATE/INT. DATE FROM ST10a, NS7a, CT72a) and (TODAY/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/INT. DATE FROM ST10a, NS7a, CT72a), did (HH5 PROVIDER) provide any services to (you/SP) other than delivering meals?

OTHMEALS	YES	1	BOX HH1
	NO	2	BOX HH3
	REFUSED	-7	BOX HH3
	DON'T KNOW	-8	BOX HH3

BOX HH1	a.	SP HAS USED VA FACILITIES (HI36=1)	1	(b)
		SP HAS NOT USED VA FACILITIES (HI36=2 OR MISSING)	2	BOX HH1A
	b.	VA FLAG SET FOR HH4/HH2 PROVIDER	1	BOX HH1A
		VA FLAG NOT SET FOR HH4/HH2 PROVIDER	2	(HH8)

Box HH2 omitted.

HH8. Is (HH2/HH5 PROVIDER) associated with a Department of Veterans Affairs, or V.A., facility?

VAPLACE	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HH8a, HH8b, HH9, and HH10 omitted.

BOX HH1A	a.	SP BELONGS TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 1 FOR ANY PLAN)	1 (b)
		SP DOES NOT BELONG TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 2 OR MISSING FOR <u>ALL</u> PLANS)	2 (HH11)
	b.	"MANAGED CARE FLAG" CODED YES FOR THIS PROVIDER	1 (HH11)
		"MANAGED CARE FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (HH10b)
		"MANAGED CARE FLAG" NOT SET FOR THIS PROVIDER	3 (HH10a)

HH10a. Is (PROVIDER) associated with (your/SP's) [{READ MANAGED CARE PLAN NAME(S) BELOW] plan?

HMOASSOC	YES	1 (HH11)
	NO	2 (HH10b)
	REFUSED	-7 (HH10b)
	DON'T KNOW	-8 (HH10b)

HH10b. (Were you/Was SP) referred to (PROVIDER) by [READ MANAGED CARE PLAN NAME(S) BELOW]?

HMOREFER	YES	1 (HH11)
	NO	2 (HH10c)
	REFUSED	-7 (HH11)
	DON'T KNOW	-8 (HH11)

HH10c. What is the most important reason (you/SP) did not use a home health provider associated with [READ MANAGED CARE PLAN NAME(S) BELOW] or a home health provider that [READ MANAGED CARE PLAN NAME(S) BELOW] would refer (you/SP) to?

	PLAN DOES NOT COVER THE SERVICE SP WANTED	1
	SP COULD NOT GET SERVICES QUICKLY ENOUGH THROUGH THE PLAN.....	2
	OFFICE NOT CONVENIENTLY LOCATED FOR THE SP	3
	PLAN PROVIDERS NOT COMPETENT/QUALIFIED TO HANDLE CONDITION/NEEDS	4
	SP DIDN'T WANT TO GO THROUGH PRIMARY CARE PHYSICIAN TO GET REFERRAL	5
	SP WANTED TO GO TO A PROVIDER NOT AVAILABLE THROUGH THE PLAN	6
NOHMOMAI	SP WANTED TO USE A PROVIDER THEY HAD PRIOR TO THEIR ENROLLMENT IN THE PLAN	7
	PLAN REFUSED TO PROVIDE THE CARE THE SP THOUGHT WAS NECESSARY	8
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	9
NOHMOMOS	PLAN ADMINISTRATIVE OBSTACLES FOR SP	10
	NOT IN A MANAGED CARE PLAN AT TIME OF EVENT	11
	SP HAD A MEDICAL EMERGENCY AND WENT OR WAS TAKEN TO THE CLOSEST PROVIDER	12
	SP WAS OUTSIDE OF THE SERVICE AREA WHEN URGENT CARE WAS NEEDED	13
	OTHER (SPECIFY)	91
	REFUSED	-7
	DON'T KNOW	-8

HH11. Between (PREV. ROUND INT. DATE/INT. DATE FROM ST10a, NS7a, CT72a) and (TODAY/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/INT. DATE FROM ST10a, NS7a, CT72a), how many times (has/did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) come to the home to help (you/SP)? [Remember to include all home health providers from (HH5 OR HH24 PROVIDER).]

TOTAL NUMBER OF TIMES	1	TOTAL NUMBER OF TIMES:
NUMBER OF TIMES PER DAY	2	NUMBER OF TIMES PER DAY:
NUMBER OF TIMES PER WEEK	3	NUMBER OF TIMES PER WEEK:
NUMBER OF TIMES PER MONTH	4	NUMBER OF TIMES PER MONTH:
REFUSED	-7 (HH12)	
DON'T KNOW	-8 (HH12)	

HELPUNIT

HELPNUM

- HH12. (Generally speaking, how long (does/did)/How long did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) stay with (you/SP)?
[PROBE: We just need to know in general.]

HOURS ONLY	1	NUMBER OF HOURS: _____
MINUTES ONLY	2	NUMBER OF MINUTES: _____
HOURS AND MINUTES	3	
REFUSED	-7 (HH13)	
DON'T KNOW	-8 (HH13)	
STAYUNIT		STAYHOUR
		STAYMIN

- HH13. (Generally speaking, (does/did)/Did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) help (you/SP) by giving any medical or nursing treatment, such as the things shown on this card? ["MEDICAL OR NURSING TREATMENT" MEANS SUCH THINGS AS APPLYING STERILE BANDAGES OR DRESSINGS, GIVING MEDICATIONS, TAKING BLOOD PRESSURE, GIVING SHOTS OR INJECTIONS.]
[PROBE: We just need to know in general.]

<div style="border: 1px solid black; padding: 5px; display: inline-block;"> SHOW CARD HH2 </div>	NEEDNURS	YES, AT LEAST ONE	1
		NO	2
		REFUSED	-7
		DON'T KNOW	-8

- HH14. (Generally speaking, (does/did)/Did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) help with (your/SP's) daily needs by doing things, such as the ones shown on this card? [HELP WITH DAILY NEEDS MEANS HELP IN USING THE TELEPHONE, DOING HOUSEWORK, PREPARING MEALS.]
[PROBE: We just need to know in general.]

<div style="border: 1px solid black; padding: 5px; display: inline-block;"> SHOW CARD HH3 </div>	NEEDMEAL	YES, AT LEAST ONE	1
		NO	2
		REFUSED	-7
		DON'T KNOW	-8

- HH15. (Generally speaking, (does/did)/Did) (HH2 OR HH19 PROVIDER/someone from HH5 OR HH24 PROVIDER) help with (your/SP's) personal care by doing things such as those shown on this card? [HELP WITH PERSONAL CARE MEANS HELP WITH BATHING, SHOWERING, DRESSING, EATING, WALKING, USING THE TOILET.]
[PROBE: We just need to know in general.]

<div style="border: 1px solid black; padding: 5px; display: inline-block;"> SHOW CARD HH4 </div>	NEEDCARE	YES, AT LEAST ONE	1
		NO	2
		REFUSED	-7
		DON'T KNOW	-8

BOX HH3	<p>a. IF COMING FROM HHS1 OR HHS2, GO TO BOX HHS5.</p> <p>b. IF THIS VISIT ADDED THROUGH HH1 AND: PROVIDER WORKED FOR SELF (HH4 = 2), GO TO HH16; PROVIDER WORKS FOR SOMEONE ELSE (HH4 = 1), GO TO HH17.</p> <p>c. IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC.</p> <p>d. IF THIS VISIT ADDED THROUGH CTRL/I OR ST, GO TO BOX ST12.</p> <p>e. IF THIS VISIT ADDED THROUGH NS, GO TO BOX NS11.</p>
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HH16. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you been/has SP been/was SP) helped at home by any other health professionals?

TEMP	YES	1 (HH2)
	NO	2 (HH18)
	REFUSED	-7 (HH18)
	DON'T KNOW	-8 (HH18)

HH17. Other than the persons who (have) visited (you/SP) from (HH5 PROVIDER) [or from the other(s) we've talked about], (have you been/has SP been/was SP) helped at home by any other health professionals [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)]? [DON'T INCLUDE ANY OTHER PERSONS COMING FROM THE SAME ORG/ AGENCY LISTED BELOW.]

TEMP	YES	1 (HH2)
	NO	2 (HH18)
	REFUSED	-7 (HH18)
	DON'T KNOW	-8 (HH18)

HH18. [Besides what you have already mentioned,] [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], because of health problems (have you received/has SP received/did SP receive) any personal care or help at home with daily needs from (any other) persons who (do/did) not live with (you/him/her), including home health aides, homemakers, friends, neighbors, or relatives?

SHOW CARD HH5	HHPFRND	YES	1 (HH19)
		NO	2 BOX MP1A
		REFUSED	-7 BOX MP1A
		DON'T KNOW	-8 BOX MP1A

HH19. Who helped (you/SP)? What is the name of the person who helped (you/him/her)?
 [ENTER NAME OF PERSON WHO HELPED, NOT NAME OF PLACE OR ORGANIZATION.]
 [ENTER ONLY ONE PERSON. DO NOT ENTER A PERSON WHO LIVES WITH SP.]

PROVNAME

HH20. Is (HH19 PROVIDER) a friend or neighbor, a relative, or some other type of home health provider?

HHFTYPE	FRIEND OR NEIGHBOR	1	BOX HH5
	RELATIVE	2	(HH21)
	OTHER TYPE OF HOME HEALTH PROVIDER	3	(HH22)
	REFUSED	-7	(HH23)
	DON'T KNOW	-8	(HH23)

HH21. How is (HH19 PROVIDER) related to (you/SP)?

BOX HH5

HHFRELAT
HHFRELOS

HH22. What kind of home health provider is (HH19 PROVIDER)?

PROVSPEC
PROVSPOS

HH23. Who does (HH19 PROVIDER) work for, that is, for what place or organization?
[PROBE: Or does (HH19 PROVIDER) work for himself/herself?]

WORKSFOR	NAME OF ORGANIZATION GIVEN	1	(HH24)
	WORKS FOR SELF	2	BOX HH4
	REFUSED	-7	BOX HH4
	DON'T KNOW	-8	BOX HH4

HH24. [Who does (HH19 PROVIDER) work for, that is, what place or organization?]
[PROBE: Who would (you/SP) call if (HH19 PROVIDER) did not show up?]
[ENTER ONLY ONE PROVIDER.]

PROVNAME
SUBPROV

HH25. What kind of place or organization is (HH24 PROVIDER)?

HHPLACE	MANAGED CARE PLAN (SUCH AS HMO)	1	BOX HH4
	MEAL PROGRAM (SUCH AS MEALS ON WHEELS)	2	(HH26)
	VISITING NURSE ASSOCIATION	3	BOX HH4
	HOME HEALTH AGENCY	4	BOX HH4
	HOSPITAL	5	BOX HH4
	PRIVATE PHYSICIAN/GROUP PRACTICE	6	BOX HH4
	HOSPICE	7	BOX HH4
	REHABILITATION OR SPORTS MEDICINE THERAPY	8	BOX HH4
	LOCAL GOVERNMENT ORGANIZATION	9	BOX HH5
	CHURCH OR COMMUNITY ORGANIZATION	10	BOX HH5
	ASSISTED LIVING/RETIREMENT HOME	11	BOX HH4
	REFUSED	-7	BOX HH4
	DON'T KNOW	-8	BOX HH4
	OTHER (SPECIFY) _____		
HHPLACOS	_____	91	BOX HH4

- HH26. Between (PREV. ROUND INT. DATE/INT. DATE FROM ST10a, NS7a, CT72a) and (TODAY/DATE OF DEATH/DATE OF INSTITUTIONALIZATION/DATE FROM ST10a, NS7a, CT72a), did (HH24 PROVIDER) provide any services to (you/SP) other than delivering meals?

OTHMEALS YES 1 **BOX HH4**
 NO 2 (HH29)
 REFUSED -7 (HH29)
 DON'T KNOW -8 (HH29)

BOX HH4	a.	SP HAS USED V.A. FACILITIES (HI36=1)	1 (b)
		SP HAS NOT USED V.A. (HI36=2 OR MISSING)	2 BOX HH4A
	b.	"V.A. FLAG" SET FOR HH19/HH24 PROVIDER	1 BOX HH4A
		"V.A. FLAG" NOT SET FOR HH19/HH24 PROVIDER	2 (HH27)

- HH27. Is (HH19/HH24 PROVIDER) associated with a Department of Veterans Affairs, or V.A., facility?

VAPLACE YES 1
 NO 2
 REFUSED -7
 DON'T KNOW -8

BOX HH4A	a.	SP BELONGS TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 1 FOR ANY PLAN) .	1 (b)
		SP DOES NOT BELONG TO A MANAGED CARE PLAN (HI10a, HI25 OR MEDICARE MANAGED CARE FLAG = 2 OR MISSING FOR <u>ALL</u> PLANS)	2 BOX HH5
	b.	"MANAGED CARE FLAG" CODED YES FOR THIS PROVIDER	1 BOX HH5
		"MANAGED CARE FLAG" CODED NO OR MISSING FOR THIS PROVIDER	2 (HH27b)
		"MANAGED CARE FLAG" NOT SET FOR THIS PROVIDER	3 (HH27a)

- HH27a. Is (PROVIDER) associated with (your/SP's) [READ MANAGED CARE PLAN NAME(S) BELOW] plan?

HMOASSOC YES 1 (HH28)
 NO 2 (HH27b)
 REFUSED -7 (HH27b)
 DON'T KNOW -8 (HH27b)

- HH27b. (Were you/Was SP) referred to (PROVIDER) by [READ MANAGED CARE PLAN NAME(S) BELOW]?

HMOREFER YES 1 **BOX HH5**
 NO 2 (HH27c)
 REFUSED -7 **BOX HH5**
 DON'T KNOW -8 **BOX HH5**

HH27c. What is the most important reason (you/SP) did not use a home health provider associated with [READ MANAGED CARE PLAN NAME(S) BELOW] or a home health provider that [READ MANAGED CARE PLAN NAME(S) BELOW] would refer (you/SP) to?

	PLAN DOES NOT COVER THE SERVICE SP WANTED	1
	SP COULD NOT GET SERVICES QUICKLY ENOUGH THROUGH THE PLAN.....	2
	OFFICE NOT CONVENIENTLY LOCATED FOR THE SP	3
	PLAN PROVIDERS NOT COMPETENT/QUALIFIED TO HANDLE CONDITION/NEEDS	4
	SP DIDN'T WANT TO GO THROUGH PRIMARY CARE PHYSICIAN TO GET REFERRAL	5
	SP WANTED TO GO TO A PROVIDER NOT AVAILABLE THROUGH THE PLAN	6
NOHMOMAI	SP WANTED TO USE A PROVIDER THEY HAD PRIOR TO THEIR ENROLLMENT IN THE PLAN	7
	PLAN REFUSED TO PROVIDE THE CARE THE SP THOUGHT WAS NECESSARY	8
	THIS SERVICE WAS COVERED BY OTHER INSURANCE SP HAS	9
NOHMOMOS	PLAN ADMINISTRATIVE OBSTACLES FOR SP	10
	NOT IN A MANAGED CARE PLAN AT TIME OF EVENT	11
	SP HAD A MEDICAL EMERGENCY AND WENT OR WAS TAKEN TO THE CLOSEST PROVIDER	12
	SP WAS OUTSIDE OF THE SERVICE AREA WHEN URGENT CARE WAS NEEDED	13
	OTHER (SPECIFY)	91
	REFUSED	-7
	DON'T KNOW	-8

Box HH4A omitted.

BOX HH5	ASK HH11 - HH15 FOR (HH19/HH24) PROVIDER. THEN GO TO BOX HH6 .
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BOX HH6	<p>IF HH19 PROVIDER IS A FRIEND OR RELATIVE (HH20 = 1 OR 2) OR WORKS FOR SELF (HH23 = 2), GO TO HH28.</p> <p>IF HH19 PROVIDER WORKS FOR SOMEONE ELSE (HH23 = 1), GO TO HH29.</p> <p>IF THIS VISIT ADDED THROUGH UTS, GO TO UTSINTRC.</p> <p>IF THIS VISIT ADDED THROUGH CRTLI OR ST, GO TO BOX ST12.</p> <p>IF THIS VISIT ADDED THROUGH NS, GO TO BOX NS11.</p>
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HH28. [Since (REF. DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you received/has SP received/did SP receive) personal care or help at home with daily needs from any other persons who (do/did) not live with (you/him/her)?

TEMP	YES	1 (HH19)
	NO	2 BOX MP1A
	REFUSED	-7 BOX MP1A
	DON'T KNOW	-8 BOX MP1A

HH29. Other than the persons who have visited (you/SP) from (HH24 PROVIDER) [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], (have you received/has SP received/did SP receive) personal care or help (at home) with daily needs from any other persons who (do/did) not live with (you/him/her)? [DON'T INCLUDE ANY OTHER PERSONS COMING FROM THE SAME ORG/AGENCY LISTED BELOW.]

TEMP	YES	1 (HH19)
	NO	2 BOX MP1A
	REFUSED	-7 BOX MP1A
	DON'T KNOW	-8 BOX MP1A

HH1. HOME HEALTH UTILIZATION AND EVENTS

MEDICAL PROVIDER SPECIALTY CODE LIST

1	DENTIST/DENTAL PROVIDER
2	MEDICAL DOCTOR
3	AUDIOLOGIST
4	CHIROPRACTOR
5	CLINICAL SOCIAL WORKER
6	DIETITIAN-NUTRITIONIST
7	HEARING THERAPIST
8	HOME HEALTH/HEALTH AIDE
9	HOMEMAKER
10	HOSPICE WORKER
11	I.V. THERAPIST
12	NURSE (RN)
13	NURSE PRACTITIONER
14	NURSE'S AIDE
15	OCCUPATIONAL THERAPIST (OT)
16	OPTOMETRIST (OD)
17	OSTEOPATH (DO)
18	PARAMEDIC
19	PHYSICAL THERAPIST (PT)
20	PHYSICIAN'S ASSISTANT
21	PODIATRIST (FOOT DOCTOR)
22	PSYCHOLOGIST
23	RESPIRATORY THERAPIST
24	SOCIAL/CASE WORKER
25	SPEECH THERAPIST
26	THERAPIST (MENTAL HEALTH)
27	X-RAY TECHNICIAN
28	LICENSED PRACTICAL NURSE (LPN)
91	OTHER MEDICAL PROVIDER SPECIALTY (SPECIFY)